

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **22691**

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1- FOR STATE REGISTRAR  |  | 2a. DATE KNOWN OF DEATH                                     |  | MONTH DAY YEAR   |  | 2b. HOUR  |  |
| CARRIE  |  | CONDON  |  | BAYLISS  |  | 9/8/1979 AM   |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  |
| female  |  | cau.  |  | Aug. 17, 1909  |  | 70 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?                                |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| Maryland  |  | U.S.A.  |  |  |  | Dorchester  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |
| Cambridge   |  | Dorchester Gen'l Hosp.                                      |  |  |  |   |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. STREET ADDRESS   |  |
| Md.   |  | Dorchester  |  | Cambridge  |  | 617 Race St.  |  |
| 14. FATHER'S NAME   |  |   |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |
| Harry   |  |   |  | Amy Marshall   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.                                    |  | 17. INFORMANT  |  |   |  |
| no  |  | 215-26-5155   |  | brother George Condon, Rt. #3, Cambridge, Md.  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY:   |  |   |  |  |  |   | Few Mins.                                    |
| IMMEDIATE CAUSE (a) <b>Suffocation</b>  |  |   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.   |  |   |  |  |  |   |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |  |   |  |
| (c)   |  |   |  |  |  |   |  |
| PART 2 (OTHER SIGNIFICANT) CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |  |  | 20. AUTOPSY?  |  |
|   |  |   |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |
|   |  | 7AM. 9/8/79   |  | Caught in burning home.  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION  |  |   |  |
|   |  | Home  |  | 617 Race St. Cambridge, Dor., Md.  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE  |  | TITLE (SPECIFY)   |  | DATE SIGNED  |  |   |  |
| <i>John Mace Jr.</i>  |  | M.D. Deputy   |  | 9/10/79  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  | ADDRESS   |  |  |  |   |  |
| John Mace Jr. M.D.  |  | Cambridge, Md.  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |
| burial  |  | Sept. 11, 1979  |  | Spedden-Seward Cem.  |  | Cambridge, Dorchester, Md.  |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR                               |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |
| Curran Funeral Home, 308 High St.   |  | SEP 17 1979   |  | <i>John Mace Jr.</i>   |  |   |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IT IS THE RESPONSIBILITY OF THE EXAMINER TO EXECUTE THE CERTIFICATE. WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 22692

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR  |  | 2a. DATE KNOWN OF DEATH   |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2b. DATE KNOWN OF DEATH   |  | 2b. HOUR  |  |
| WEBSTER   |  | 2b. DATE KNOWN OF DEATH   |  | 2b. HOUR  |  |
| BAYLISS   |  | 2b. DATE KNOWN OF DEATH   |  | 2b. HOUR  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  |
| male  |  | cau.  |  | July 27, 1916   |  |
| 6. AGE (IN YEARS)   |  | 7. DATE OF BIRTH  |  | 8. AGE (IN YEARS)   |  |
| 63 YRS.   |  | July 27, 1916   |  | 63 YRS.   |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 10. CITY OR TOWN OF DEATH                                       |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION                          |  |
| Maryland  |  | Cambridge   |  | Dorchester Gen'l Hosp   |  |
| 12. CITIZEN OF WHAT COUNTRY?  |  | 13. MARRIED   |  | 14. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| U.S.A.  |  | NEVER MARRIED   |  | Dorchester  |  |
| 15. CITY OR TOWN OF DEATH   |  | 16. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION        |  | 17. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                      |  |
| Cambridge   |  | Dorchester Gen'l Hosp   |  | seafood packer  |  |
| 18. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 19. KIND OF BUSINESS OR INDUSTRY                                |  | 20. SHELLFISH   |  |
| Md.   |  | Dorchester  |  | shellfish   |  |
| 21. STATE   |  | 22. COUNTY  |  | 23. CITY OR TOWN  |  |
| Md.   |  | Dorchester  |  | Cambridge   |  |
| 24. FATHER'S NAME   |  | 25. MOTHER'S MAIDEN NAME  |  | 26. STREET ADDRESS  |  |
| Bernard   |  | Eva   |  | 617 Race Street   |  |
| 27. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  | 28. SOCIAL SECURITY NO.   |  | 29. INFORMANT   |  |
| no  |  | 220-10-6825   |  | Mrs. Eva M. McNaughton  |  |
| 30. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | 31. IMMEDIATE CAUSE (a)   |  | 32. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                  |  |
| 8902  |  | Suffocation   |  | Few Mins.   |  |
| 33. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  | 34. DATE OF OPERATION   |  | 35. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                  |  |
|   |  | 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                 |  |
|   |  | 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                 |  |
| 36. 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  | 37. 21b. TIME OF INJURY   |  | 38. 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |
| 7AM 9/8/79  |  | 7AM 9/8/79  |  | Caught in Burning Home.   |  |
| 39. 21d. INJURY OCCURRED WHILE AT WORK  |  | 40. 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 41. 21f. LOCATION   |  |
| Home  |  | Home  |  | 617 Race St. Cambridge, Dor., Md.   |  |
| 42. 22a. I certify that I took charge of the remains described above, held on death resulted from:                                      |  | 43. Autopsy   |  | 44. Inspection  |  |
| Natural causes  |  | X   |  | X   |  |
| 45. TITLE (SPECIFY)   |  | 46. DATE SIGNED   |  | 47. REGISTRAR'S SIGNATURE   |  |
| Deputy  |  | 9/10/79   |  | John Mace Jr. M.D.  |  |
| 48. ACTUAL SIGNATURE  |  | 49. ADDRESS   |  | 50. NAME OF CEMETERY OR CREMATORY   |  |
| John Mace Jr. M.D.  |  | Cambridge, Md.  |  | Spedden-Seward Cem. Cambridge, Dorchester, Md.                                    |  |
| 51. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 52. DATE  |  | 53. LOCATION  |  |
| burial  |  | Sept. 11, 1979  |  | Cambridge, Dorchester, Md.  |  |
| 54. FUNERAL DIRECTOR  |  | 55. DATE REC'D. BY REGISTRAR                                    |  | 56. REGISTRAR'S SIGNATURE   |  |
| Curran Funeral Home, 308 High St.   |  | SEP 17 1979   |  | John Mace Jr. M.D.  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 2 2 6 9 3

1 - FOR  
STATE  
REGISTRAR

|  |  |  |   |   |  |  |   |
|--|--|--|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARGARENE R. BELL</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 17 79</b> |   |  | 2b. HOUR<br><b>12<sup>05</sup> AM</b>  |   |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 30, 1906</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Dorchester Co.</b> MD   |   |
| 10. CITY OR TOWN OF DEATH<br><b>MAxY Cambridge Dor.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>General Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                                       |   |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Dorchester</b>   |   | 13c. CITY OR TOWN<br><b>Cambridge</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>August C. Rasche</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Friederika Spilker</b>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |  |   |
| 16b. SOCIAL SECURITY NO.<br><b>21-32-6124</b>  |  | 17. INFORMANT ADDRESS<br><b>Mr. J. Howard Bell Item # 13</b>   |   |   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>GENERALIZED METASTATIC ADENOCARCINOMA</b><br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>CARCINOMA OF BREAST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>1968</b> |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MONTHS</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>   |  |  |   |   |  |  |   |
| 19a. DATE OF OPERATION<br><b>11-29-68</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CARCINOMA OF LEFT BREAST</b>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (1) this hospital attended the deceased from <b>NOVEMBER 19 68</b> to <b>9-17 19 79</b> , that (2) we lost saw the deceased alive on <b>9-16 19 79</b> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)   |  |  |   |   |  |  |   |
| 22b. SIGNATURE<br><b>James F. McCarter, M.D.</b>   |  |  |   | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>9-17-79</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES F. MCCARTER, M.D.</b>  |  |  |   | 22e. ADDRESS<br><b>400 AURORA STREET<br/>CAMBRIDGE, MD. 21613</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>9-19-79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dor. Mem. Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cambridge Dor. Md</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Thomas Funeral Home Box 348 Maryland</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 20 1979</b>   |  |  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |   |   |  |  |   |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 2 2 6 9 4

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |   | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH  |   | 2b. HOUR   |  |
| FIRST MIDDLE LAST  |  | MONTH DAY YEAR   |   | HOURS MIN.   |  |
| William Raymond Chase  |  | 9 11 1979  |   | 2:15 AM  |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>     |  |
| Male   | Negro  | Dec. 2, 1895   | 83 YRS.   | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |  |
| Maryland   | USA  | Dorchester MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Cambridge  | Dorchester General Hospital  | Carpenter  |   |  |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   |  |  |
| 13a. STATE   | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS  |  |
| Md.  | Dor.   | Camb.  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 721 Washington St.   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |   |  |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |   |  |  |
| William Robert Chase   |  | Sarah E. Phillips  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT (Nephew) ADDRESS   |  |
| No   |  | 216-38-8770  |   | Camb., Md.   |  |
|  |  |  |   | William R. Boardley 618 Robbin St.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)   |  |  |   |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |   |  |  |
| IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>  |  |  |   |  |  |
| 4049   |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |  |  |
| (b) <u>Arteriosclerosis, Nephrosclerosis</u>   |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |  |  |
| (c)  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |  |
| <u>Left leg severe right foot - AKA</u>  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |  |
| 8-8-79   |  | <u>Left leg severe right foot</u>  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |   |  |  |
|  |  | P.M. 19  |   |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |   | STREET CITY OR TOWN COUNTY STATE   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7-2-79</u> to <u>9-11-79</u> , that (I) (we) last saw the deceased alive on <u>9-10-79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death) |  |  |   |  |  |
| 22a. SIGNATURE   |  | DEGREE   |   | 22c. DATE SIGNED   |  |
| <u>J. Edwin Fossett</u>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |   |  |  |
| <u>J. Edwin Fossett</u>  |  | <u>P.O. Box 570 Cambridge Md.</u>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial   |  | 9-17-97  |   | Waugh Meth. Cem.   |  |
|  |  |  |   | Cambridge Dor, Md.   |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE RECEIVED BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |  |
| NAME ADDRESS   |  |  |   |  |  |
| <u>L.H. Boardley 603 Washington St. Camb. Md.</u>  |  | SEP 17 1979  |   | <u>Henry McBrady</u>   |  |



**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

7 9 2 2 6 9 5

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |  |  |   |                                    |  |
|---|--|---|--|---|---|--|--|---|------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>GERTHARD MAY DAVIS   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9 18 79                         |   |   | 2b. HOUR<br>10 A.M.  |  |   |                                    |  |
| 3. SEX<br>F   |  | 4. RACE<br>W  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 13 1984  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. 95             |   |                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md, Ws 4   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>W.S.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>DORCHESTER MD. |   |                                    |  |
| 10. CITY OR TOWN OF DEATH<br>Cambridge  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>EAST SH. HOSP CENTER |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                                    |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Dor.   |  | 13c. CITY OR TOWN<br>Cambridge  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Rebecca Mitchell  |  |   | 13e. STREET ADDRESS<br>501 Radiance Drive                                     |  |  |   |                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-44-8733  |  | 17. INFORMANT<br>ADDRESS<br>Miss Mable Wright, Cambridge Md.  |   |  |  |   |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>GENERALIZED AS.</u><br>Approximate interval between onset and death:<br>3 hours<br>years<br>years |  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |   |  |  |   |                                    |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |                                    |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/18</u> 19 <u>79</u> , to <u>9/18</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>9/18</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.            |  |   |  |   |   |  |  |   |                                    |  |
| 22b. SIGNATURE<br><u>George H. Buch</u>   |  |   | DEGREE<br><u>MD</u>  |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED<br><u>9/19/79</u> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GEORGE H BUCH MD   |  |   | 22e. ADDRESS<br>EAST SH HOSP CENTER<br>CAMBRIDGE, MD 21613             |   |   |  |  |   |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b. DATE<br>Sept. 21, 1979  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Oxford Cemetery                         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE             |   |                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Thomas Funeral Home, Cambridge, Md.   |  |   | 25a. DATE REC'D BY REGISTRAR<br>SEP 26 1979                            |   |   |  |  |   |                                    |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |   |  |   |   |  |  |   |                                    |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

SO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

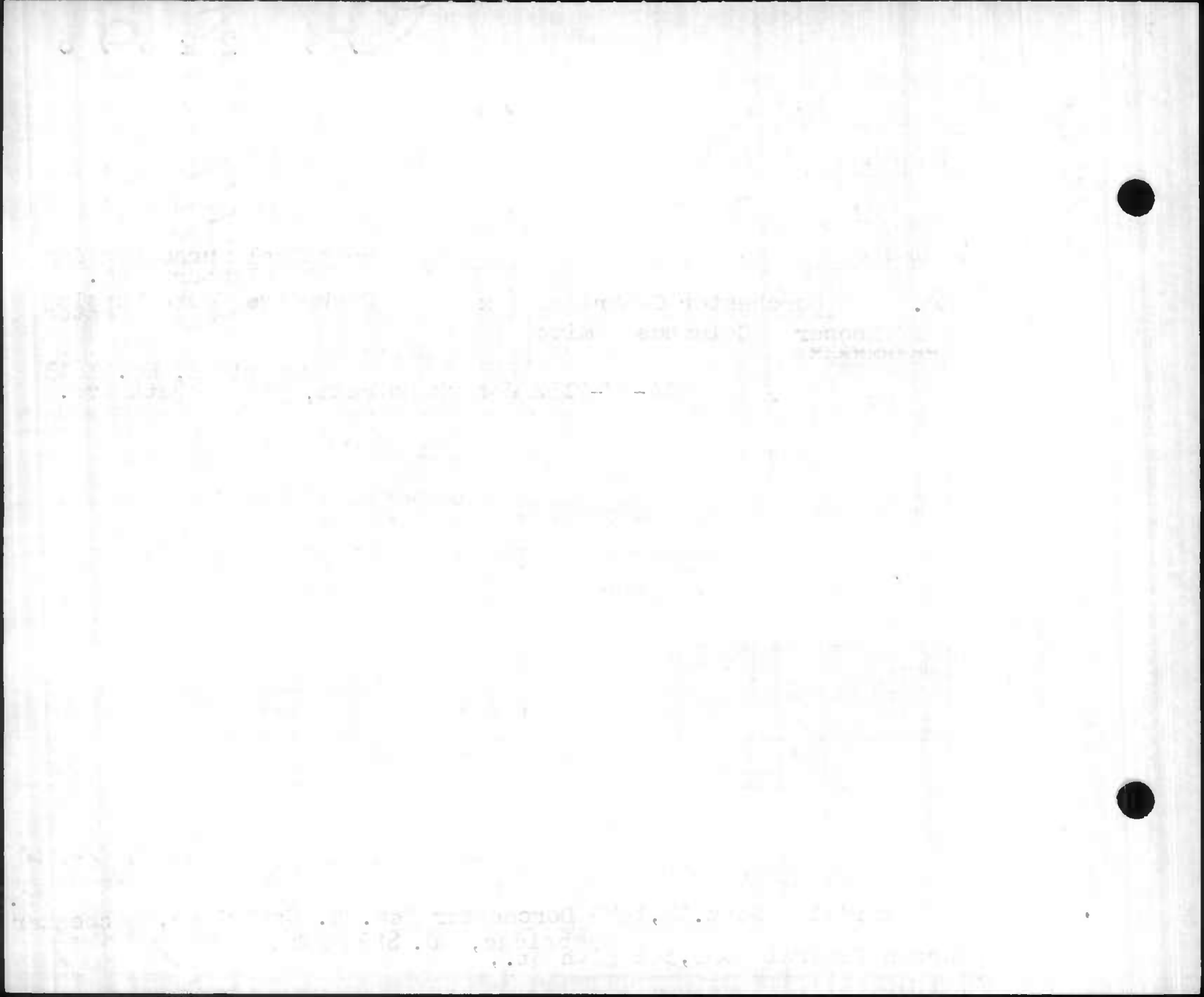
1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 2 2 6 9 6

|  |   |  |  |   |   |
|--|---|--|--|---|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Willie L. Delaha  |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>09 11 79   |   | 2b HOUR<br>M  |
| 3 SEX<br>Female  | 4 RACE<br>1-Cau   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>04 14 92  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>87<br>YRS                                     |   |
| 7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  | 7c CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Dorchester MD                            |   |
| 10 CITY OR TOWN OF DEATH<br>Cambridge  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Dorchester General Hosp. |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>practical nurse nursing     |   | 12b KIND OF BUSINESS OR INDUSTRY<br>520 Glenburn Ave.<br>Cambridge House Nursing Center |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Md.  | 13b COUNTY<br>Dorchester  | 13c CITY OR TOWN<br>Cambridge  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS<br>Cambridge   |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Hooper Columbus Smith   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Susan Twilley  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no                      |   |   |
| 16b SOCIAL SECURITY NO.<br>214-07-7132   |   | 17 INFORMANT<br>Joseph McKnett, 312 Talbott Ave.   |  |   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 5188 C. H. Failure<br>DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Infection<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c) |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>Organic B. Syndrom, Bilateral Anomali, ASCVD  |   |  |  |   |   |
| 19a DATE OF OPERATION  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>        |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                        |   |  |  |   |   |
| 22b. SIGNATURE<br>E. Tanman  |   | DEGREE<br>MD   |  | 22c. DATE SIGNED  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22e ADDRESS<br>17 Franklin St. Cambridge Md  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>burial  |   | 23b. DATE<br>Sept. 14, 1979  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dorchester Mem. Pk. Cambridge, Dorchester |   |
| 24 FUNERAL DIRECTOR<br>NAME<br>Curran Funeral Home, 308 High St.,  |   | 23d. LOCATION<br>CITY OR TOWN<br>Cambridge, Md.  |  | 23e. DATE OF REGISTRATION<br>SEP 19 1979  |   |

BP.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

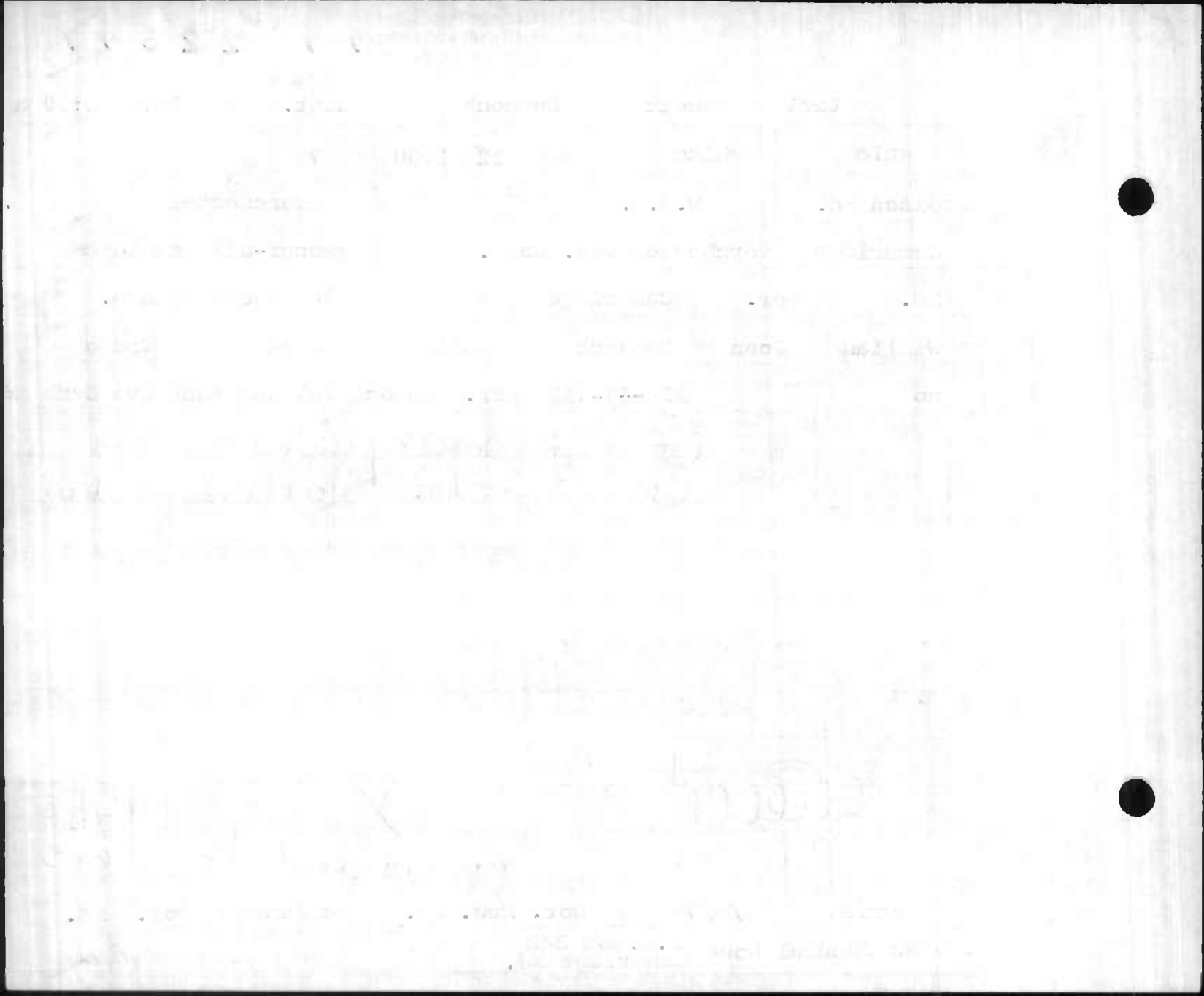
1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 22697

|  |  |   |  |   |   |  |  |  |  |
|--|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Carl Emmett Dunnock</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept. 2 1979</b> |   | 2b. HOUR<br>MIN<br><b>5:30 a</b>  |  |  |  |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 12 1900</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br><b>79</b>  |  | IF UNDER 1 YEAR<br>IF UNDER 24 HRS.<br>HOURS MIN     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Madison Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Dorchester</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cambridge</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Dorchester Gen. Hosp.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>grocer-self</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>employed</b> |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Dor.</b>  |  | 13c. CITY OR TOWN<br><b>Cambridge</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>307 Choptank Ave.</b>      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William John Dunnock</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sally Jane Trego</b>  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-07-7138</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Dunnock 307 Choptank Ave Camb Md</b>  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b><br><b>410-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>b. <b>Acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>c. <b>hcs</b><br><b>1 day</b> |  |   |  |   |   |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/1</b> 19 <b>79</b> , to <b>9/2</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>9/1</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, (I) (we) did not view the body after death.)  |  |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>A.R. WILKE</b>  |  |   |  | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>9/4/79</b>                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A.R. WILKE</b>   |  |   |  | 22e. ADDRESS<br><b>400 Maryland Ave - 21613</b>   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>burial</b>   |  | 23b. DATE<br><b>9/5/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dor. Mem. Pk.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cambridge Dor. Md.</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Thomas Funeral Home</b>   |  |   |  | P.O. Box 348<br><b>Cambridge Md.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 10 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Barney McCreedy</b> |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 22698

FOR  
1 - STATE  
REGISTRAR

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Maurice C DYOTT   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9/22/79 |   |  | 2b. HOUR<br>3 A.M.   |  |
| 3. SEX<br>male   |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 05 88  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>St. Michaels  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Dorchester MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Cambridge   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Cambridge House Nursing Center |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Waterman  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Seafood   |  |
| 13a. STATE<br>Md   |  | 13b. COUNTY<br>Talbot   |  | 13c. CITY OR TOWN<br>St. Michaels   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br>203 Morengo St.   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary E. Willey   |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Dyott  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>212-12-1653A   |  | 17. INFORMANT<br>ADDRESS<br>Ruth D. Daffin St. Michaels, Maryland   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 436-<br>DUE TO, OR AS A CONSEQUENCE OF (b) Generalized atherosclerosis<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>D. Mellitus, Degenerative Brain Syndrome  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on 9-21-19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                        |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>E. Torman  |  | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>9/22/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>E. Torman   |  | 22e. ADDRESS<br>Cambridge, Maryland   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Sept 26, 1979  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Olivet Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>St. Michaels Talbot Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Dorothy E. Leonard   |  | ADDRESS<br>St. Michaels, Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 01 1979  |  | 25b. REGISTRAR'S SIGNATURE<br>Dorothy E. Leonard   |  |

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UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbonpapers: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   | 7 9 2 2 6 9 9<br>REG. NO.                              |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Perry Stewart Flegel  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>September 24, 1979 |   |  | 2b. HOUR P. M.<br>3:05 P. M.   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>July 13, 1905  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Superior, Wisc.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Dorchester MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Cambridge  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Dorchester General Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Teacher  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>High School   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Dorchester   |  | 13c. CITY OR TOWN<br>Hurlock  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  | 13e. STREET ADDRESS<br>North Main Street   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William Alexander Fleugel  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Margaret Bishop   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>213-22-7961A  |  | 17. INFORMANT ADDRESS Maryland 21643<br>Mrs. Margaret B. Flegel, N. Main St., Hurlock   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Bilateral Stroke - respiratory failure hrs.<br>4/40<br>DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac Arrest<br>DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Heart Disease<br>2 m, approx years |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Septic, Rheumatic heart Disease, Ventricular arrhythmia  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/19 19 79 to 9/24 19 79, that (I) (we) lost saw the deceased alive on 9/23 19 79, and that it is (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) and not view the body after death.              |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>[Signature]   |  |   |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Ann R. Wilke, M.D.   |  |   |  | 22e. ADDRESS<br>400 Maryland Avenue, Cambridge, Md. 21613   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Sept. 27, 1979   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Unity Washington Cem.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Hurlock, Dorchester, Maryland  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Frampton-Hawkins Funeral Home, 216 N. Main St.   |  |   |  | ADDRESS<br>Federalsburg,  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 01 1979  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 22700

FOR  
1. STATE  
REGISTRAR

REG. NO.

|  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Henry - Gooden  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9 10 79                              |   | 2b. HOUR<br>4:25 PM   |
| 3. SEX<br>male   | 4. RACE<br>Negro  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9-5-1906  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS   |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>S. Carolina  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Dorchester MD.  |   |
| 10. CITY OR TOWN OF DEATH<br>Cambridge   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Dorchester General Hosp. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laborer |   | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br>Md.  |   | 13b. COUNTY<br>Dor.   | 13c. CITY OR TOWN<br>Camb.  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>605 Wells St.  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unknown                    |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-16-6407  |   | 17. INFORMANT<br>ADDRESS<br>Ruby Hester 515 Huber St. Camb. Md.                                 |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebral hemorrhage<br>431-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Arteriosclerosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) He had previous eva   |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>5 days   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from about 12 19 79 to September 10 19 79, that (I) (we) lost<br>saw the deceased alive on September 10 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   |   |   |   |   |
| 22b. SIGNATURE<br>Dr. J. Barroso   |   |   |   | 22c. DATE SIGNED<br>9-10-79   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CARLOS F. BARROSO   |   |   |   | 22e. ADDRESS<br>Hurlock Md  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |   | 23b. DATE<br>9-15-79  | 23c. NAME OF CEMETERY OR CREMATORY<br>Bethel AME Cem.                       |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cambridge Dor. Md.  |
| 24. FUNERAL DIRECTOR<br>NAME<br>L. M. Boardley 603 Wash. St. Camb., Md   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>SEP 17 1979  |   |
|  |   |   |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |   |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 2 2 7 0 1

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |
|---|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ESTHER V. HAYWARD</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 12 79</b>                                |   | 2b. HOUR<br><b>5:40 P.M.</b>                                      |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 10 10</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.   |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Dorchester County MD</b>                             |   |
| 10. CITY OR TOWN OF DEATH<br><b>Cambridge</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Dorchester General Hosp.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY                                 |
| 13a. STATE<br><b>md.</b>  |  | 13b. COUNTY<br><b>Dorchester</b>  | 13c. CITY OR TOWN<br><b>Cambridge</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Cornish</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Mobek Cornish</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>202-18-9891</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Linda Watkins - (daughter)</b>                                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Adenocarcinoma of pancreas</b><br><b>1579</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>with metastases</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year (3)</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |   |
| 19a. DATE OF OPERATION<br><b>Nov 3/1978</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Above</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 1</b> , 19 <b>78</b> , to <b>Sept 12</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Sept 12</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                   |  |   |  |   |   |
| 22b. SIGNATURE<br><b>Lewis M. Burdette</b>  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>12 Sept 79</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lewis M. Burdette</b>   |  | 22e. ADDRESS<br><b>4 Aurora St. Cambridge Md 21613</b>  |  |   |   |
| 23a. BURIAL CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>9/16/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WAUGH</b>  |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>CAMBRIDGE DOG. MD</b>  |  | 23e. DATE REC'D. BY REGISTRAR<br><b>SEP 17 1979</b>   |  | 23f. REGISTRAR'S SIGNATURE<br><b>Ruby Melnyk</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>ST. CLAIR F. HOME</b>  |  |   |  |   |   |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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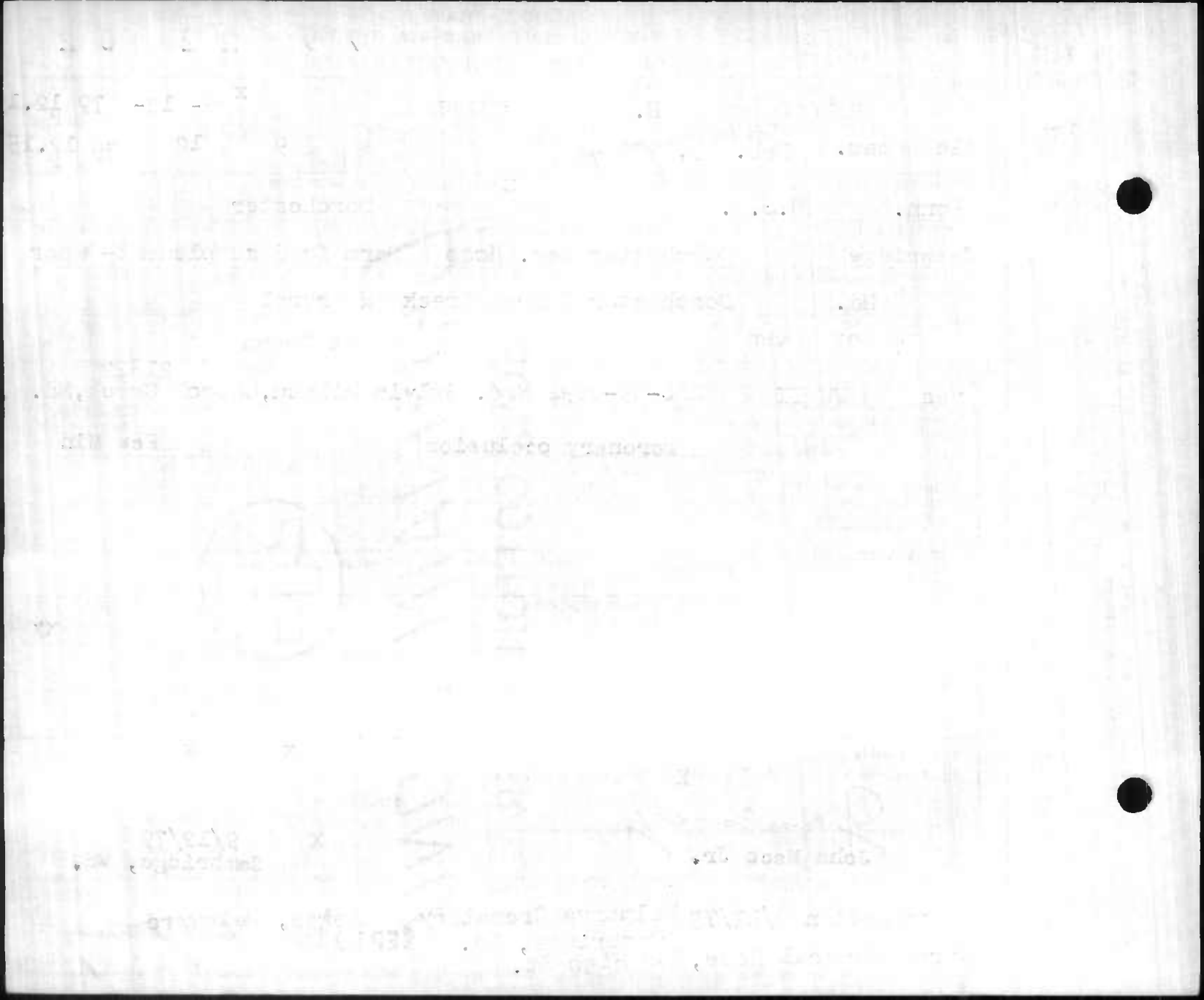
**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

2 2 7 0 2

**FOR STATE  
HEALTH DEPT.**

|   |                 |  |  |   |   |  |  |   |  |   |            |            |  |
|---|-----------------|--|--|---|---|--|--|---|--|---|------------|------------|--|
| 1. DECEASED-NAME<br>(Type or Print)   |                 |  |  | First   | Middle  | Last   | 2a. DATE KNOWN OF DEATH<br>Month Day Year  |   |  |   | 2b. HOUR   |            |  |
| HAROLD H. HILDUM  |                 |  |  |   |   |  | 9- 12- 79  |   |  |   | 12.15 P.M. |            |  |
| 3. SEX<br>male  | 4. RACE<br>cau. | 5. DATE OF BIRTH<br>Feb. 13, 1909  | 6. AGE (In years last birthday)<br>70 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS  |   | IF UNDER 24 HRS<br>HOURS MIN   |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year  |  |   |            | 12.15 P.M. |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Penn.  |                 | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                       |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Dorchester Md.   |  |   |  |   |            |            |  |
| 10. CITY OR TOWN OF DEATH<br>Cambridge  |                 |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Dorchester Gen. Hosp |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br>Farm feed supplement |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Owner |   |            |            |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.  |                 |  | 13b. COUNTY<br>Dorchester  |   | 13c. CITY OR TOWN<br>Church Creek   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br>rural            |   |            |            |  |
| 14. FATHER'S NAME<br>First Middle Last<br>? Not Known   |                 |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>? Not Known  |   |  |  |   |  |   |            |            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>yes  |                 |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>WW II 266-09-8092               |   | 17. INFORMANT<br>Mrs. Sylvia Hildum, Church Creek, Md.                          |  |  | ADDRESS 21622   |  |   |            |            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                 |  |  |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Few Min |            |            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                 |  |  |   |   |  |  |   |  |   |            |            |  |
| 19a. DATE OF OPERATION  |                 |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |            |            |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                 |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |  |   |  |   |            |            |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                 | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |  |  |   |  |   |            |            |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                 |  |  |   |   |  |  |   |  |   |            |            |  |
| ACTUAL SIGNATURE<br><br>EXAMINER'S NAME (Type)<br>John Mace Jr.   |                 |  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |  |  | 22b. DATE SIGNED<br>9/12/79<br>ADDRESS (Street, city, town, or county) Cambridge, Md. |  |   |            |            |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>cremation 9/12/79  |                 | 23b. DATE<br>9/12/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Delmarva Crematory  |   |  | 23d. LOCATION (City or Town) (County) (State)<br>Lewes, Delaware   |   |  |   |            |            |  |
| 24. FUNERAL DIRECTOR<br>Curran Funeral Home, 308 High St.   |                 |  |  | 25. DATE<br>SEP 19 1979   |   | 25b. REGISTERED<br>  |  |   |  |   |            |            |  |

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201  
 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1, and 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 2 7 0 3

FOR  
1. STATE  
REGISTRAR

REG. NO.

|   |   |   |   |  |  |   |  |
|---|---|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Howard M. C. Jones</b>                  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 17 79</b>                             |  |  | 2b. HOUR<br><b>9:30 A.M.</b>                        |  |
| 3. SEX<br><b>male</b>   | 4. RACE<br><b>white</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 11 93</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                      | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Dorchester</b> MD.                        |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cambridge</b>                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Cambridge House Reg. Fac.</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Farmer</b>    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Farming</b> |  |
| 13a. STATE<br><b>Md.</b>  |   | 13b. COUNTY<br><b>Dorchester</b>  | 13c. CITY OR TOWN<br><b>Church Creek</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>Box 65 Church Creek, Md.</b> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edwin B. Jones</b>                   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Ellen Richardson</b> |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |   | 16b. SOCIAL SECURITY NO.<br><b>220-01-9999</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Leonard Simmons, Madison, Md., 21648</b>         |  |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>C.H. Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).<br><b>Organic B. Syndrome, ASCVD, Ca of Prostate</b>   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>9 9</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>E. Tanman MD</b>  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>9-17-79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E. Tanman</b>  |  | 22e. ADDRESS<br><b>17 Franklin St Cambridge, Md</b>                    |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Sept. 19, 79</b>                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Old Trinity Churchyard, Church Creek, D.C.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>Thomas Funeral Home, Cambridge, Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 20 1979</b>                    |  | 25b. REGISTRAR'S SIGNATURE<br><b>Henry Maloney</b>                                      |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, the medical examiner must be notified at once.

M

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 2 2 7 0 4

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>George A. Keene</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9-6-79</b>  |   | 2b. HOUR<br><b>11:55 AM</b>   |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12-14-97</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Dorchester</b> MD.                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cambridge</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Dorchester General</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>School Bus Op.</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Ret.</b> |
| 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>Chesapeake</b>  | 13c. CITY OR TOWN<br><b>Church Creek</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>Rural</b>              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>W. Henry Keene</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Willie Todd</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-09-3822</b>  |   | 17. INFORMANT<br><b>Mrs. Mary Sherman, Cambridge, Md.,</b>                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Electro-Mechanical Dissection</b><br><b>410-</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost:<br>b) <b>Acute Myocardial Infarction</b><br>c) <b>ASA</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>ASA</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>ASA</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b><br><b>Summers</b> |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |   | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Sept. 8, 1979</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dorchester Mem. Park, Cambridge, Md.</b>         |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE       |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Thomas Funeral Home, Cambridge, Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 10 1979</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

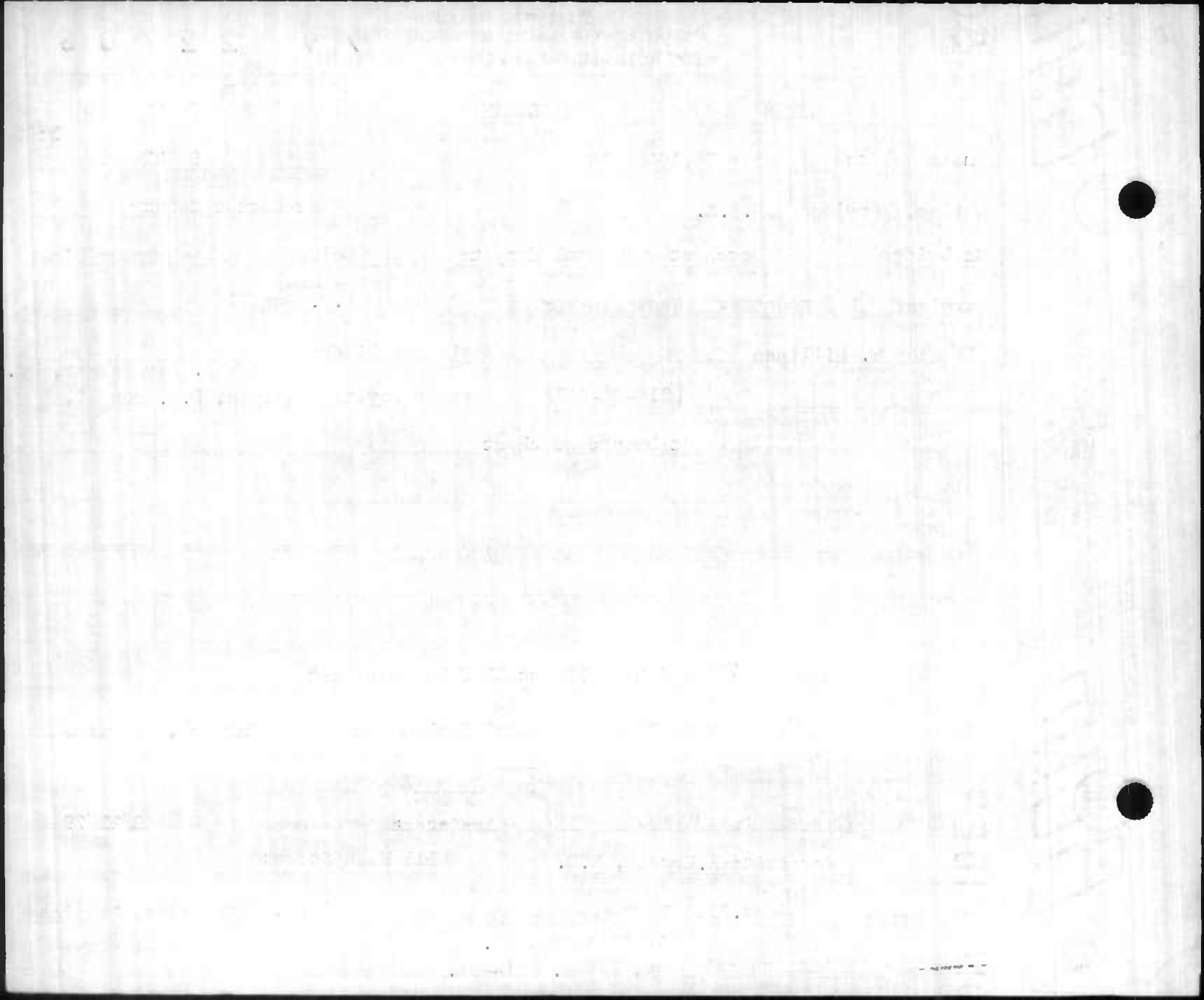
BP

DHMH-17  
1VR A15 ME (5)  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 22705

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE KNOWN OF DEATH  |  | MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH                             |  |
| LEWIS  |  | male   |  | black   |  | July 29, 1940                                |  |
| MILLIGAN   |  | 39 YRS.  |  | 39 YRS.   |  | 39 YRS.                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH         |  |
| Shiloh, Maryland   |  | U.S.A.   |  | WIDOWED   |  | Dorchester County MD.                        |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| Cambridge  |  | Dorchester General Hospital  |  | Welder  |  | Power Plant                                  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. STREET ADDRESS                          |  |
| Maryland   |  | Dorchester   |  | East New Market   |  | P.O. Box 71                                  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |  | 16b. SOCIAL SECURITY NO.                     |  |
| Timothy M. Milligan  |  | Essie Mae Pinder   |  | No  |  | 219-36-6477                                  |  |
| 17. INFORMANT  |  | ADDRESS  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| Drayna Taylor Milligan, P.O. Box 71.   |  | E. New Market, Md.   |  | PART I DEATH WAS CAUSED BY:   |  |  |  |
|  |  |  |  | IMMEDIATE CAUSE (a) Stabwound of chest  |  |  |  |
|  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |
|  |  |  |  | (b)   |  |  |  |
|  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |
|  |  |  |  | (c)   |  |  |  |
|  |  |  |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  |  |  |
|  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 21a. EXTERNAL CAUSE WAS  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH |  | 9-20 1979  |  | stabbed by assailant  |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION   |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK                   |  | in an Inn  |  | Pearl Harbor Inn  |  | Hurlock, Maryland                            |  |
| 22a. I certify that I took charge of the remains described above, held an                              |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion   |  | death resulted from:  |  |  |  |
|  |  | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |  |  |
| ACTUAL SIGNATURE   |  | TITLE (SPECIFY)  |  | DATE SIGNED   |  |  |  |
| Margarita A. Korell, M.D.  |  | M.D. Assistant   |  | 9/22/79   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  | ADDRESS  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE                                    |  |
|  |  | 111 Penn Street  |  | Burial  |  | Sept. 25, 1979                               |  |
| 24. FUNERAL DIRECTOR   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | COUNTY STATE                                 |  |
| Frampton-Hawkins Funeral Home, 216 N. Main St.   |  | Petersburg Cemetery  |  | Hurlock, Dorchester, Maryland   |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  | 26. DATE REC'D. BY REGISTRAR  |  | 26. REGISTRAR'S SIGNATURE                    |  |
| OCT 01 1979  |  | L. M. Brady  |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

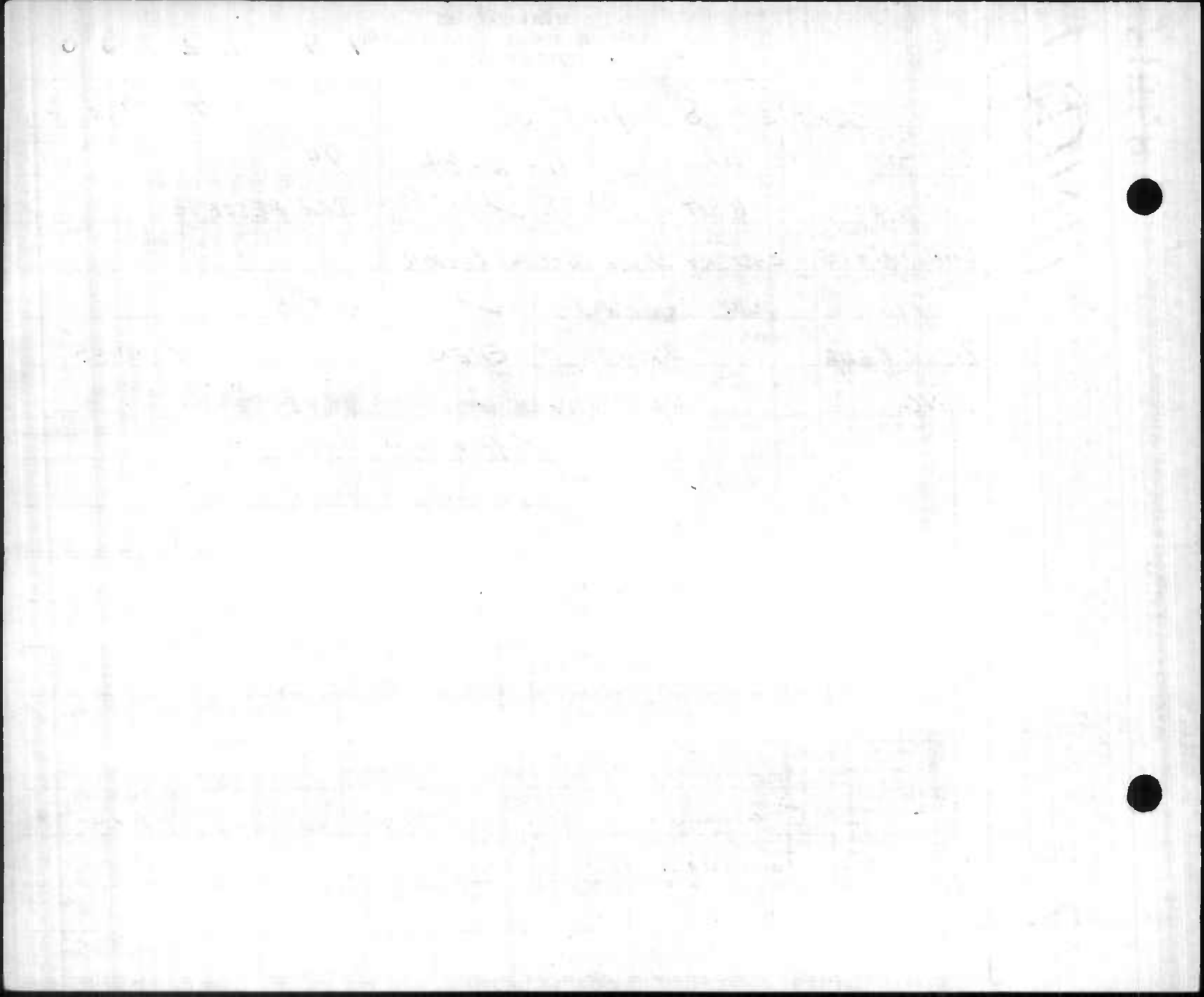
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |                                      |                                    |
|---|--|---|--|---|--|---|--|--------------------------------------|------------------------------------|
| 1. FOR STATE REGISTRAR  |  |   |  |   | REG. NO. 9 22706   |   |  |                                      |                                    |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GERTIE S. Phillips</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 20 79</b>                        |   |  |                                      |                                    |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11-2-84</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>94</b>  |  | 7b. HOUR<br><b>6 P M</b>             |                                    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>DORCHESTER</b> MD.                                   |  |                                      |                                    |
| 10. CITY OR TOWN OF DEATH<br><b>CAMBRIDGE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>EASTERN SHORE Hospital CENTER</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY    |                                    |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>DOR</b>   |  | 13c. CITY OR TOWN<br><b>CAMBRIDGE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>Rt #50</b> |                                    |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>BEAUCHAMP</b> <b>WRIGHT</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELLEN</b> <b>KNOWLES</b> |   |  |                                      |                                    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-07-6986</b>   |  | 17. INFORMANT (daughter) ADDRESS<br><b>Mrs. Flora Freeny, Riverview, Fla.</b>   |  |   |  |                                      |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a): <b>Myocardial Infarction</b><br><b>410-</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DU TO, OR AS A CONSEQUENCE OF (b): <b>Generalized Atherosclerosis</b><br>DU TO, OR AS A CONSEQUENCE OF (c):<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |   |  |                                      |                                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Psychosis - Cerebral atherosclerosis</b>   |  |   |  |   |  |   |  |                                      |                                    |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>    |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |                                      |                                    |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |                                      |                                    |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |                                      |                                    |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |                                      |                                    |
| 22b. SIGNATURE<br><b>E. Tanman</b>  |  |   |  |   | DEGREE<br><b>MD</b>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                      | 22c. DATE SIGNED<br><b>9-20-79</b> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E. Tanman</b>   |  |   |  |   | 22e. ADDRESS<br><b>Cambridge, Md.</b>  |   |  |                                      |                                    |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>9/24/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mardela Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Mardela, Wicomico, Maryland</b>                |  |                                      |                                    |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>HOLLOWAY FUNERAL HOME, Salisbury, Md.</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 25 1979</b>                          |   | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McBrady</b>   |                                      |                                    |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

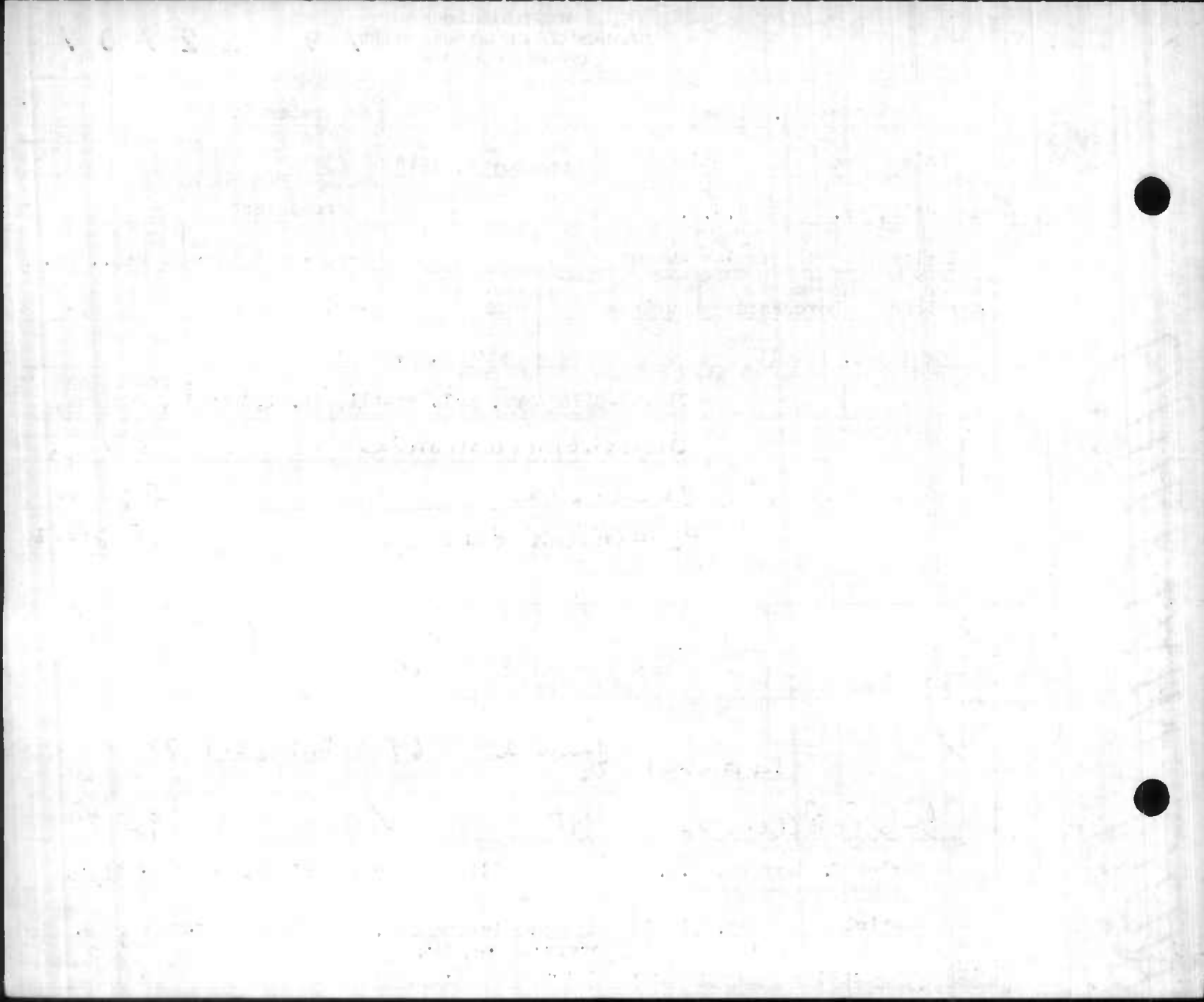
9 2 2 7 0 7

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Adam A. Powell</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 1, 1979</b>   |   | 2b. HOUR<br><b>P.</b>  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>December 9, 1898</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Shaw Hill, Md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Dorchester</b> MD.                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Hurlock</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Taylor Avenue</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Trackman &amp; foreman Penn. RR.</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Maryland</b>   |   | 13b. COUNTY<br><b>Dorchester</b>  | 13c. CITY OR TOWN<br><b>Hurlock</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>Taylor Avenue</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George E. Powell</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Katie E. Hesse</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>717-07-9676</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Lula Powell, Rt. 1, Box 15, Hurlock, Maryland 21643</b>     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b><br>3320<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Cachexia</b><br>(c) <b>Parkinson's disease</b>                            |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>5 years</b><br><b>15 years</b>                         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 2, 1969</b> to <b>September 1, 1979</b> , that (I) (we) last saw the deceased alive on <b>September 1, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Carlos F. Barroso</b>  |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>9.5.79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Carlos F. Barroso, M.D.</b>   |   | 22e. ADDRESS<br><b>Collins Avenue, Hurlock, Maryland 21643</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>Sept. 4, 1979</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Unity Washington Cem.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hurlock, Dorchester, Md.</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Frampton-Hawkins Funeral</b>   |   | ADDRESS<br><b>Federalburg, Md.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 10 1979</b>   |  |
|   |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McCready</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M/7/77  
(VR A 15 (4))

DO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |                     |  | 7 9 2 2 7 0 8   |     |            |           |
|---|--|---|--|---|--|--|--|---------------------|--|-----------------|-----|------------|-----------|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |  |  |                     |  |                 |     |            |           |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH   |  | MONTH           | DAY | YEAR       | 2b. HOUR  |
| Roger F. Scott  |  |   |  |   |  |  |  | 9-11-79             |  |                 |     |            | 7:55 P.M. |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  | IF UNDER 1 YEAR     |  | IF UNDER 24 HRS |     |            |           |
| MALE  |  | CAU   |  | 9 12 8  |  | 70 YRS   |  | MONTHS              |  | DAYS            |     | HOURS MIN. |           |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |                     |  |                 |     |            |           |
| MD.   |  | USA   |  |   |  | Dor. County MD   |  |                     |  |                 |     |            |           |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                           |  |                     |  |                 |     |            |           |
| Cambridge   |  | Dor. General Hosp.  |  | Farmer  |  | Farming  |  |                     |  |                 |     |            |           |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?                                       |  | 13e. STREET ADDRESS |  |                 |     |            |           |
| MD.   |  | Dor   |  | Hurlock   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | Rt 1 Box 3 B        |  |                 |     |            |           |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |  |  |                     |  |                 |     |            |           |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST   |  |   |  |  |  |                     |  |                 |     |            |           |
| Will Scott  |  | Edith Miles   |  |   |  |  |  |                     |  |                 |     |            |           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS  |  |                     |  |                 |     |            |           |
| No  |  | 215-36-2267   |  | Doris B. Scott  |  | Hurlock, Maryland  |  |                     |  |                 |     |            |           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF LUNG-<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) CARCINOMA OF LUNG-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Days<br>Days |  |   |  |   |  |  |  |                     |  |                 |     |            |           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>RENAL CELL CARCINOMA   |  |   |  |   |  |  |  |                     |  |                 |     |            |           |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                     |  |                 |     |            |           |
|   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                     |  |                 |     |            |           |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |                     |  |                 |     |            |           |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |                     |  |                 |     |            |           |
| 22a. I certify that (I) (the hospital) attended the deceased from 9/11 1979, to 9/11 1979, that (I) (we) last saw the deceased alive on 9/11 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |                     |  |                 |     |            |           |
| 22b. SIGNATURE  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED   |  |                     |  |                 |     |            |           |
| David B. Stoeckle M.D.  |  |   |  |   |  | 9/11/79  |  |                     |  |                 |     |            |           |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |   |  |  |  |                     |  |                 |     |            |           |
| David B. Stoeckle M.D.  |  | 117 High St., Cambridge, Md.  |  |   |  |  |  |                     |  |                 |     |            |           |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |  |                     |  |                 |     |            |           |
| Burial  |  | 9-14-79   |  | Unity Washington Cem.   |  | Hurlock Dor Md.  |  |                     |  |                 |     |            |           |
| 24. FUNERAL DIRECTOR<br>NAME  |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                                     |  |                     |  |                 |     |            |           |
| Zeller Funeral Home   |  | East New Mkt., Md   |  | SEP 19 1979   |  | Rickey McCreedy  |  |                     |  |                 |     |            |           |

BP

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY



1. Name of the plant or animal  
2. Date of collection  
3. Locality  
4. Collector's name  
5. Number of specimens  
6. Remarks

7. Description of the specimen  
8. Notes on the specimen  
9. Name of the collector  
10. Date of collection  
11. Locality  
12. Collector's name  
13. Number of specimens  
14. Remarks

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 2 7 0 9

REG. NO.

|  |  |   |  |   |  |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Spedden Chaplain A. |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9 22 79           |   |  | 2b. HOUR<br>M  |  |  |  |  |
| 3. SEX<br>male   |  | 4. RACE<br>Cauc   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 13 91   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Dor. Co. Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Dorchester MD.                               |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Cambridge                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Dorchester General |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Farmer           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Agriculture                   |  |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>Dor.   |  | 13c. CITY OR TOWN<br>Camb.  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>Camb. Hse. P.O. Box 159                     |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Dexter Spedden   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Annie Applegarth   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |  | 17. SOCIAL SECURITY NO.<br>218-36-3469 |  |  |  |
| 18. INFORMANT<br>Mr. Donald Spedden                        |  |   | 19. ADDRESS<br>Route #3, Box 166<br>Cambridge, Md. 21613 |   |  |  |  |  |  |  |

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

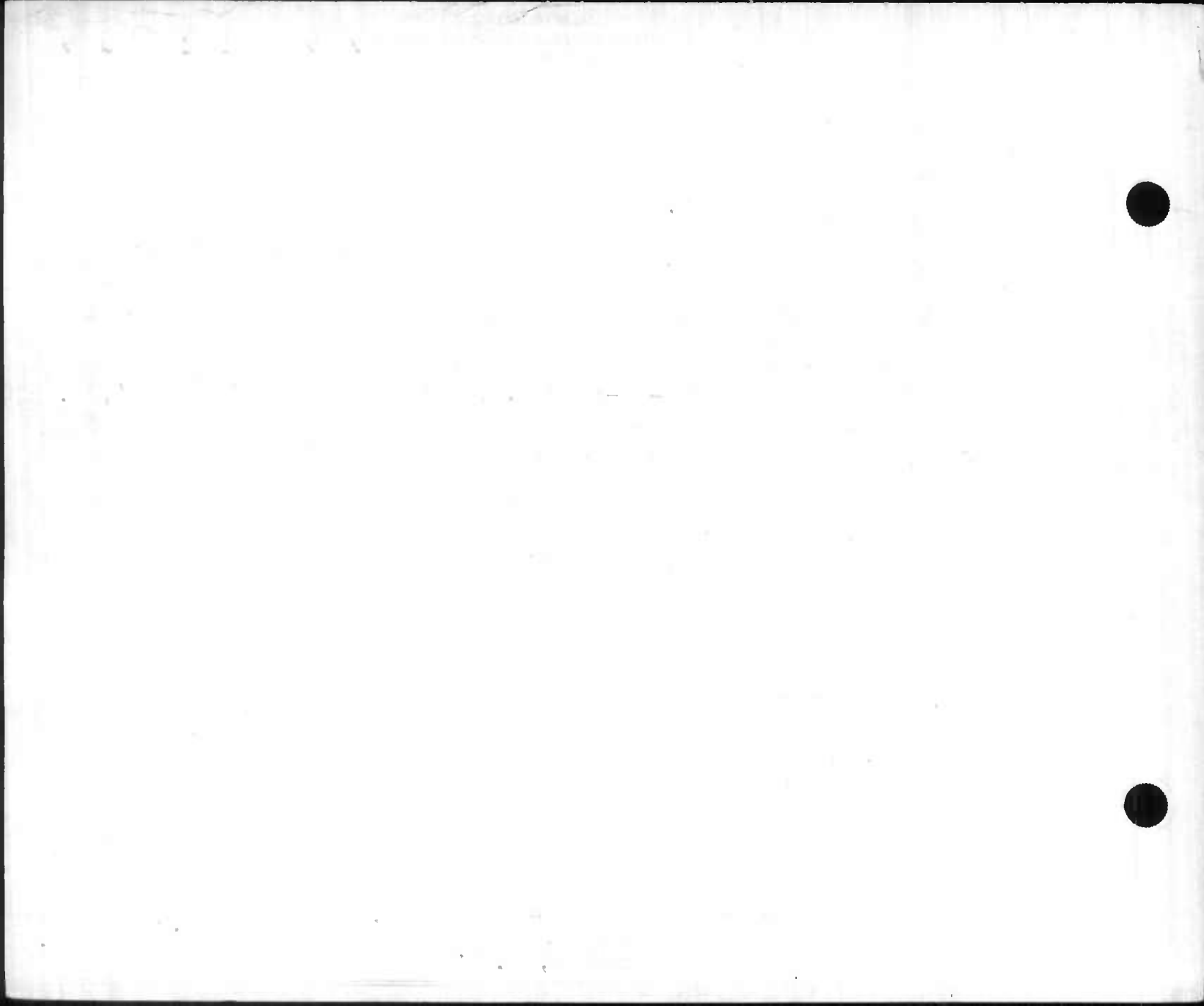
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

## PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>John A. Ruly MD   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS  |  |  |  |

|   |  |                      |  |   |  |   |  |
|---|--|----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial |  | 23b. DATE<br>9-25-79 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Spedden Seward Cem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Neck District, Dorchester Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Curran Funeral Home |  |                      |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 28 1979              |  | 25b. REGISTRAR'S SIGNATURE<br>Ruthy McCreedy                                |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 22710

1- FOR  
STATE  
REGISTRAR

|  |                         |  |  |   |   |   |  |  |
|--|-------------------------|--|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>John Thorpe Staylor III</b>                      |                         |  | 2a. DATE KNOWN<br>OF ESTI-<br>MATED<br><b>9 9 79</b> |   |   | 2b. HOUR<br><b>6:00 a.m.</b>  |  |  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 28, 1959</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>20 YRS.</b> | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>0 0</b>   | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b>                                      | 2c. DATE<br>PRONOUNCED<br>DEAD<br><b>9 9 79</b>   |  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br><b>Maryland</b>                            |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>Dorchester County, MD</b>                     |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cambridge</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Dorchester General Hsp.</b> |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br><b>Roofer</b> |   | 12b. KIND OF BUSINESS<br>OR INDUSTRY<br><b>Roofing Co.</b> |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |                         |  |  |   |   |   |  |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Towson</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 13e. STREET ADDRESS<br><b>1007 Timber Trail Road</b>                                       |                         |  |  |   |   |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>J. Thorpe Staylor, Jr.</b>                    |                         |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Helen Wladkowska</b>  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>         |                         | 16b. SOCIAL SECURITY NO.<br><b>213-52-1043</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>J. Thorpe Staylor, Jr. Same as #13.</b>  |   |   |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Multiple injuries**

DUE TO, OR AS A CONSEQUENCE OF

8120  
Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.

(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>4:00AM 9/9 79</b>          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Driver in multiple automobile collision</b> |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br><b>roadway</b> |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Route #50 Vienna, Dorchester Co, MD</b>                                 |  |

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL  
SIGNATURE

TITLE (SPECIFY)

M.D.

**Assistant**

MEDICAL EXAMINER

DATE

SIGNED

**9/10/79**

EXAMINER'S NAME  
(TYPE OR PRINT)

**HORMEZ R. GUARD, M.D.**

ADDRESS

**111 Penn Street, Balto., MD 21201**

|   |  |                                    |  |   |  |  |  |
|---|--|------------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                   |  | 23b. DATE<br><b>Sept. 12, 1979</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oaklawn Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b> |  |                                    |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 13 1979</b>           |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                         |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

JO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 22711

|   |  |   |                               |   |                                     |  |   |
|---|--|---|-------------------------------|---|-------------------------------------|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>NINA E TRUJILLO   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>9 00 79  |                               |   |                                     | 2b. HOUR<br>1200 P.M.  |   |
| 3. SEX<br>Female  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 8, 1904  |                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74   |                                     | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Dorchester MD.  |                                     |  |   |
| 10. CITY OR TOWN OF DEATH<br>Cambridge  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Dorchester Genl. Hospital |   |                               | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |                                     | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Dor.   | 13c. CITY OR TOWN<br>Woolford | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>Rural Rt. 16 |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Travers S. Thompson   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br>Elizabeth Jones   |                               |   |                                     |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>217-12-9432   |                               | 17. INFORMANT<br>ADDRESS<br>A Mrs. Florence T. Bramble, Woolford, Md.                           |                                     |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>1991 IMMEDIATE CAUSE (a) Carcinoma of Stomach to Liver 6 cm<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |                               |   |                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 weeks |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):   |  |   |                               |   |                                     |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                     |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                     |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-13 19 79, to 9-20 19 79, that (I) (we) lost saw the deceased alive on 9-20 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |                               |   |                                     |  |   |
| 22b. SIGNATURE<br>S. W. Bramble   |  |   |                               | DEGREE<br>Surgeon   |                                     | 22c. DATE SIGNED<br>9-21-79  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |                               | 22e. ADDRESS  |                                     |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Sept. 22, 1979   |                               | 23c. NAME OF CEMETERY OR CREMATORY<br>Old Trinity Churchyard, Church Creek, Dor.                |                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Thomas Funeral Home, Cambridge, Md.   |  |   |                               | 25a. DATE REC'D. BY REGISTRAR<br>SEP 26 1979  |                                     | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |   |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PN 3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR 415 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 22712

|  |  |   |  |   |  |   |  |  |  |   |  |                |  |
|--|--|---|--|---|--|---|--|--|--|---|--|----------------|--|
| FOR<br>1- STATE<br>REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |   |  |   |  |  |  |   |  | REG. NO. 22712 |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>J.   |  | MIDDLE<br>C.  |  | LAST<br>Williams  |  | 7a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR |  | 2b. HOUR<br>P. M  |  |                |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY<br>12 1967  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>67 YRS.           |  | 7c. DATE<br>PRONOUNCED<br>DEAD   |  | 2d. HOUR<br>4:20 PM   |  |                |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Fla.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Dorchester County |  | 10. CITY OR TOWN OF DEATH<br>Hurlock DOA   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Dorchester General Hospital |  |                |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>Laborer  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |  | 13a. STATE<br>MD  |  | 13b. COUNTY<br>Dor.                                       |  | 13c. CITY OR TOWN<br>Hurlock   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lula Williams  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No.  |  | 16b. SOCIAL SECURITY NO.<br>267-10-4025                   |  | 17. INFORMANT<br>Peggy Dotson  |  | ADDRESS<br>Hurlock, Md.   |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>410-<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>Few Mins.  |  |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |  |  |  |   |  |                |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |   |  |                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |                |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |   |  |   |  |   |  |  |  |   |  |                |  |
| ACTUAL<br>SIGNATURE  |  | TITLE (SPECIFY)<br>M.D. Deputy  |  | MEDICAL EXAMINER  |  |   |  | DATE<br>SIGNED 9/28/79   |  |   |  |                |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  | John Mace Jr. M.D.  |  | ADDRESS<br>Cambridge, Md.   |  |   |  |  |  |   |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>10/3/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lincoln Memorial  |  | 23d. LOCATION<br>CITY OR TOWN<br>Miami,                   |  | COUNTY<br>Dade,  |  | STATE<br>Fla.   |  |                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Perry A Reese  |  | ADDRESS<br>North St. Milford, Del.  |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 28 1979  |  | 25b. REGISTRAR'S SIGNATURE<br>Jeffrey K. Brady            |  |  |  |   |  |                |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 2 2 7 1 3

REG. NO.

|   |  |  |   |                            |  |
|---|--|--|---|----------------------------|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |   | 2b. HOUR                   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2a. DATE OF DEATH  |   | 2b. HOUR                   |  |
| Amy Virginia Windsor  |  | September 13, 1979   |   | 6:50 am                    |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR            |  |
| Female  | Caucasian  | Feb. 10, 1896  | 83 YRS.   | IF UNDER 24 HRS            |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                            |  |
| Maryland  | USA  |  | Dorchester County MD.   |                            |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                            |  |
| Cambridge   | Dorchester General   | Postal Clerk   | Retired   |                            |  |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS        |  |
| Maryland  | Dorchester   | Hurlock  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | South Main St.             |  |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |   |                            |  |
| John Windsor  | Blanche Harper   | No   |   |                            |  |
| 16b. SOCIAL SECURITY NO.  | 17. INFORMANT  | ADDRESS  |   |                            |  |
| 213-01-5522   | Ritchie Windsor  | P.O. Box 205 Hurlock Md  |   |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |   |                            |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |   |                            |  |
| IMMEDIATE CAUSE (a) <u>Cerebral myocardial infarction</u>   |  |  |   |                            |  |
| 410- <u>410-</u> DUE TO, OR AS A CONSEQUENCE OF <u>Coronary Heart Disease</u>   |  |  |   |                            |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |   |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |                            |  |
| <u>Cortic Stenosis</u>  |  |  |   |                            |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                            |  |
|   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                            |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |                            |  |
|   | HOUR A.M. MONTH DAY YEAR   |  |   |                            |  |
|   | P.M. 19  |  |   |                            |  |
| 21d. INJURY OCCURRED  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION  |   |                            |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | STREET CITY OR TOWN COUNTY STATE   |   |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/13</u> , 19 <u>79</u> , to <u>9/13</u> , 19 <u>79</u> , that (I) (we) lost  |  |  |   |                            |  |
| saw the deceased alive on <u>9/13</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. |  |  |   |                            |  |
| 22b. SIGNATURE  | DEGREE   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |   | 22c. DATE SIGNED           |  |
| <u>Ann K Wilko</u>  |  |  |   | 9/13/79                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   | 22e. ADDRESS   |  |   |                            |  |
| Ann K Wilko   | 400 Maryland Ave 21613   |  |   |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION   |                            |  |
| Burial  | 9/16/79  | Unity Washington Cem.  | HURLOCK Dor. Md.  |                            |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE |  |
| Zeller Funeral Home, East New Mkt. Md.  |  | SEP 24 1979  |   | <u>Jeffrey McCreedy</u>    |  |

